Exhibit E

CORRECTION DEPARTMENT
CITY OF NEW YORK

INJURY TO INMATE REPORT

Page 1 of 2 Pages | Form: 167R-A Rev.: 10/3/19 Ref.: Dir. 4516R-D

INSTRUCTIONS: One copy to Clinic Lock Box, One Copy to Inmate Medical File and Original with completed Investigation to Security.

Command:	Date:	COD/UOF #:	Injury #:
MDC	8-31-20	4068/20	7105

TO BE COMPLETED BY EMPLOYEE (PLEASE PRINT CLEARLY).

Inmate Name (Last Name, First Name): Rodriguez Peter

Location Where Injury Occurred:	Inmate's Housing Area:	NYSID #:	Book & Case/Sentence #:
3 cell	9 South	09839298P	349160309O

Details: On August 31 2020 at approximately 1815hrs inmate Rodriguez Peter B/C 349160309O NYSID 09839298P created a still fire in his cell #3. Fire was extinguished resulting in a Use of force with DOC staff

Supervisor Notified (Print Last Name, First Name, Rank, Shield #):	Date:	Time:
Shaday Gibson Capt 1046	8-31-20	1815 Hrs.

Employee: I ☐ (Did) ☒ (Did Not) Witness This Injury.	Employee Full Name (print):	Employee Signature:	Rank/Title:	Shield/ID#:
	Mcintosh	[signature]	C/O	11757

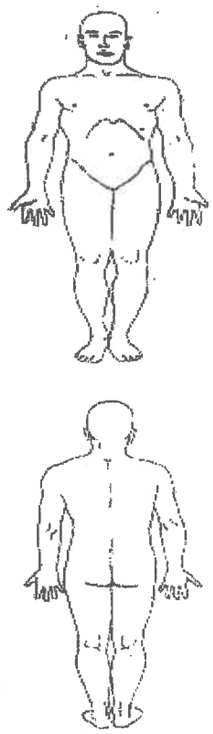
TO BE COMPLETED BY MEDICAL STAFF ONLY - (PLEASE PRINT CLEARLY)

Date of Injury:	Reported for Medical Attention:	Inmate Refused Medical Attention:	Visible Injuries:
8/31/20	Date 8/31/20 Hrs. 1134 hrs.	☒ Yes ☐ No	☐ Yes ☒ No

Nature/Reported Mechanism of Injury:

Pt denies injury/pain. Pt further refuses medical services. No signs of gross injury

Medical Staff Must Note Location of Injury:



Serious injuries confirmed during initial evaluation
(Select "Pending - Requires Further Evaluation" if additional testing / imaging / follow-up needed):

- ☐ Laceration requiring sutures, staples or glue (e.g. dermabond)
- ☐ Fracture
- ☐ Clinical Nasal Fracture
- ☐ Dislocation
- ☐ Tendon Tear
- ☐ Amputation
- ☐ Structural injury to organ (e.g. corneal abrasion, hepatic laceration)
- ☐ Post-concussive syndrome or head injury requiring imaging such as CT or MRI
- ☐ Blistering burn involving the face or >9% of total body surface area
- ☒ NO SERIOUS INJURY
- ☐ Pending - Requires Further Evaluation

Treatment: None Indicated

Disposition and Transportation Requirements (If applicable):
Please check which apply

☐ Urgicare / X-Ray ☐ Hospital Transfer: ☐ EMS ☐ Intra-Departmental Transfer

☒ None / Return to Housing Area

Initially Triaged/Treated By/~~Examined~~ By (Print and Sign Full Name):	Date:	Time:
Christopher Peters / Christopher Peters, MHP, PA	8/31/20	1834 Hrs

I certify that the cause of injury as stated herein is to my knowledge true and medical attention was provided:

Inmate Signature:	B&C / Sentence #:	Date:
X Refused	349160309O	8/31/20

Witnessed By (Signature):	Rank/Title:	Shield /I.D. #:	Date:
[signature]	C/O	11757	8/31